COUNTY OF LOS ANGELES

DEPARTMENT OF HEALTH SERVICES

# DHS COMMUNITY PARTNERS
# PRIMARY CARE FORMULARY ADDITION/REVISION REQUEST

DATE

INSTRUCTIONS

1. REQUEST MUST BE TYPED OR HAND WRITTEN.
2. FILL OUT COMPLETELY INCLUDING REQUIRED SIGNATURES.
3. ATTACH SUPPORTING SCIENTIFIC REFERENCES AND EVIDENCE.
4. ATTACH COMPLETED CONFLICT OF INTEREST DISCLOSURE SIGNED BY REQUESTING PHYSICIAN.
5. SUBMIT VIA FAX TO DHS PHARMACY AFFAIRS OFFICE AT **213-975-9623.** REQUEST WILL BE REVIEWED AT A FUTURE PRIMARY CARE PANEL COMMITTEE MEETING.

EVALUATION CRITERIA:

- NEED (RELATIVE TO THE DISEASE STATES AND CONDITIONS OF PATIENTS TREATED)
- EFFECTIVENESS (EFFICACY, PHARMACOKINETIC PROPERTIES, BIOEQUIVALENCE, THERAPEUTIC EQUIVALENCE)
- SAFETY (ADVERSE EFFECTS, MEDICATION SAFETY CONSIDERATIONS)
- FINANCIAL (PHARMACOECONOMIC IMPACT)

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|---|---|---|
| **REQUESTED DRUG** | GENERIC NAME | |
| | BRAND NAME AND MANUFACTURER | |
| | DOSAGE FORMS AND STRENGTHS | |
| **TYPE OF REQUEST** (PLEASE "X") | ☐ ADDITION | ☐ RESTRICTION CHANGE |
| | ☐ NEW STRENGTH/DOSAGE FORM | ☐ DELETION |
| **DESCRIPTION OF REQUEST** (PLEASE "X") | ☐ A NEW PRODUCT WITH PHARMACOLOGIC EFFECTS UNLIKE OTHER FORMULARY PRODUCTS | |
| | ☐ AN IMPROVEMENT ON A FORMULARY PRODUCT | NAME OF DRUG |
| | DELETE FORMULARY DRUG ☐ YES ☐ NO | EXPLAIN BELOW |
| **REASON FOR REQUEST**<br>PLEASE INCLUDE PHARMACOLOGICAL EFFECTS AND PROPOSED USE.<br>IF THIS DRUG IS SIMILAR TO A STANDARD ITEM, LIST THE ADVANTAGES OF THE STANDARD ITEM AND ADVANTAGES OF THIS DRUG | | |
| **FORMULARY RESTRICTION RECOMMENDATION** | | |

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|---|---|---|
| PHYSICIAN'S PRINTED NAME | SERVICE | MAIL LOCATION |
| PHYSICIAN'S SIGNATURE | TELEPHONE NUMBER | E-MAIL ADDRESS |
| COMMUNITY PARTNER AGENCY CMO SIGNATURE | TITLE | ESTIMATED MONTHLY CONSUMPTION |
| FOR PHARMACY AND THERAPEUTICS COMMITTEE USE<br>☐ APPROVED ☐ NOT APPROVED | | DATE |

*Updated 04/08/2016*